Department of _____

WORKABILITY FORM

_____

Phone: 406-_____-_____ Fax: 406-_____-_____ ***Contact: _____***

NOTE: This form is to be used as a communication tool among the employee, the health care provider, and the employer.

Worker Info

Employee Name		Health Care Provider Name:	
Employee's SSN:		Health Care Provider Phone:	
Injury Date:	Claim Number:	Date of current visit:	Date of next visit:

Provider Info

Released for Work? (Check all that apply)

☐ **Employee has reached Maximum Medical Improvement (MMI)** ☐ **Employee has not reached Maximum Medical Improvement (MMI)**

☐ **Employee is released to *FULL DUTY* *with no restrictions as of:* _____.**

☐ **Employee may perform *MODIFIED DUTY* (if available) from*:* _____ *to* _____.**

☐ **Employee may work *LIMITED HOURS* from*:* _____ *to* _____.**

☐ **Employee *is not released for any work* from*:* _____ *to* _____.**

Objective findings indicate employee should remain off work

Provider to complete if restricted duty is needed

Employee can:	**Not Permitted at this time**	**Permitted, but limited to:**			**Specific Comments, as needed**
		8 hours	**4 hours**	**__ hours**	
Perform work-related thought processes					
Sit					
Stand/Walk					
Climb (ladder/stairs)					
Bend/Stoop					
Squat/Kneel					
Crawl					
Reach **L**eft – **R**ight – **B**oth					
Work above Shoulders **L – R – B**					
Use Keyboard **L – R – B**					
Wrist Flexion/Extension) **L – R – B**					
Fine manipulation **L – R – B**					
Drive a motor vehicle					
Lift, carry, push or pull 1 – 5 lbs					
Lift, carry, push or pull 6 – 10 lbs					
Lift, carry, push or pull 11 – 20 lbs					
Lift, carry, push or pull 21 – 30 lbs					
Lift, carry, push or pull 31 – 40 lbs					
Lift, carry, push or pull 41 – 50 lbs					

Is the employee involved in any treatment that might affect his/her ability to work safely? ☐YES ☐NO

If "YES," is the employee safe to perform the above restricted duties as indicated? ☐YES ☐NO

Additional comments:

Signatures

Employee Signature: _____ Phone: _____ Date: _____

Health Care Provider Signature: _____ Phone: _____ Date: _____

☐**MD/DO** ☐**DC** ☐**ARNP** ☐**PA-C** ☐**Other, please specify: _____**

☐**Copy retained by Health Care Provider** ☐**Copy given to employee**